

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011209

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 128Primary Registration District No. 2000Registrar's No. 337

FILED MAR 25 1963

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Rogersville</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Rt. # 3</u>	

3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>PEARL</u> Last <u>FARROW</u>			4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-22</u>	9. AGE (last birthday) <u>41</u>	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Turners, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Frank Rose</u>		13b. MOTHER'S MAIDEN NAME <u>Ruberson</u>		14. NAME OF HUSBAND OR WIFE <u>Jack</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mary Olds, Rt. #3, Rogersville, Mo</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PORTAL VEIN OBSTRUCTION</u> DUE TO (b) <u>THROMBOSIS, OLD</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>21 YEARS OR MORE</u>
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PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III: If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>  </u> COUNTY <u>  </u> STATE <u>  </u>	
21. I attended the deceased from <u>1942</u> to <u>3/1/63</u> and last saw her/him alive on <u>3/1/63</u> Death occurred at <u>7 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22. SIGNATURE <u>Glenn O. Turner M.D.</u>		22b. ADDRESS <u>609 Cherry, Springfield</u>		22c. DATE SIGNED <u>3/19/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-5-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Heights</u>	23d. LOCATION (City, town, or county) <u>Greene Co., Mo.</u>	
24. FUNERAL DIRECTOR <u>Wm. K. Ferrell, Rogersville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-21-63</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Meeton</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/591 03972 039034 15 167 08 09 466X101112 4-013

Form 3-2-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer \_\_\_\_\_

Signed Wm. K. Terrell

Licensed Embalmer No. 4910

P. O. Address Rogersville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.